MDR Tracking Number: M5-04-1548-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 01-30-04.

The IRO reviewed therapeutic procedures, conference by physician, unlisted service, WP-somato sensory test, WP-needle electromyography, prolonged evaluation, muscle testing extremity, analysis of data stored in computer, conductive paste, needles only sterile, unlisted modality, hot/cold pack therapy, electrical stimulation unattended, office visit with manipulation, office visit, neuromusclear re-education, therapeutic exercises and mechanical traction rendered from 03-10-03 through 11-13-03 that were denied based upon "V" and "U".

The IRO determined that the services reviewed **were** medically necessary for dates of service 03-10-03 through 05-20-03. The IRO determined that the services reviewed **were not** medically necessary for dates of service 05-21-03 through 11-13-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 05-18-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99213 and 99213-MP for dates of service 03-10-03 through 07-02-03 (15 DOS) denied with denial code "D" (duplicate). The carrier did not specify what service CPT codes 99213 and 99213-MP were duplicates to. Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of $1008.00 ($48.00 X 21 DOS).

CPT code 99199 dates of service 03-11-03, 07-01-03 and 10-31-03 denied with denial code "D" (duplicate). The carrier did not specify what services CPT code 99199 were duplicates to. Reimbursement is recommended per the 96 Medical Fee Guideline and the Medical Fee Guideline effective 08-01-03 in the amount of $75.00 ($25.00 X 3 DOS).

CPT code 95999-WP date of service 03-11-03 denied with denial code "N" and "F" (not documented). Documentation submitted by the requestor meets documentation criteria. Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of $880.00.

CPT code 93740 date of service 03-11-03 denied with denial code “G” (global). The carrier per Rule 133.304(c) did not specify which code 93740 was global to. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of $84.00.

CPT code 99213-MP dates of service 03-26-03 through 04-09-03 (5 DOS) denied with denial code “K” (procedures billed are outside the scope of the provider’s practice and/or limitations). The services performed are within the provider’s practice. Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of $240.00 ($48.00 X 5 DOS).

The respondent provided an EOB for CPT code 99199 date of service 04-02-03. However, the EOB did not provide a denial code. Additional reimbursement is recommended per the 96 Medical Fee Guideline in the amount of $24.77 ($25.00 billed minus carrier payment of $.23).

CPT codes 99213 and 99213-MP dates of service 04-02-03 through 04-23-03 (5 DOS) denied with denial code “F” (fee guideline reduction). No payment has been made by the carrier. Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of $240.00 ($48.00 X 5 DOS).

CPT code 97112-59 date of service 04-19-03 (4 units) denied with denial code “F” (fee guideline reduction). Additional reimbursement is recommended per the 96 Medical Fee Guideline in the amount of $35.00 ($140.00 billed minus carrier payment of $105.00).

CPT code 99361 dates of service 04-11-03 through 05-23-03 (6 units) denied with denial code “D” (duplicate). The carrier did not specify which CPT code 99361 was a duplicate to. Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of $318.00 ($53.00 X 6 units).

Review of CPT code 99199 dates of service 04-14-03 through 08-08-03 (5 DOS) revealed that neither the requestor nor the respondent submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. No reimbursement is recommended.

Review of CPT code 97112-59 date of service 05-02-03 revealed that neither the requestor nor the respondent submitted an EOB. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for an EOB. No reimbursement is recommended.

Review of CPT code 97110-59 dates of service 05-02-03 and 05-13-03 revealed that neither the requestor nor the respondent submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. No reimbursement is recommended.

CPT code 97110-39 date of service 05-14-03 denied with denial code “D” (duplicate). Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order

payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.

CPT code 99199 dates of service 08-05-03 through 08-25-03 (5 units) denied with denial code "G" (global). The carrier per Rule 134.202(a)(4) did not specify which code 99199 was global to. Reimbursement is per the Medical Fee Guideline effective 08-01-03 in the amount of $125.00 ($25.00 X 5 units).

HCPCS code E0943 date of service 08-13-03 denied with denial code "F" (fee guideline reduction). Additional reimbursement per the Medical Fee Guideline effective 08-01-03 is recommended in the amount of $3.41 ($38.00 billed minus carrier payment of $34.59).

CPT code 97545-WH date of service 08-15-03 denied with denial code "A" (preauthorization). Reimbursement per the Medical Fee Guideline effective 08-01-03 is recommended in the amount of $128.00. However the requestor only listed $102.40 in dispute therefore this is the recommended reimbursement.

CPT code 97546-WH date of service 08-15-03 denied with denial code "A" (preauthorization). Reimbursement per the Medical Fee Guideline effective 08-01-03 is recommended in the amount of $384.00. However the requestor only listed $307.20 in dispute therefore this is the recommended reimbursement.

CPT code 99199 date of service 08-15-03 denied with denial code "A" (preauthorization). CPT code 99199 does not require preauthorization. Reimbursement per the Medical Fee Guideline effective 08-01-03 is recommended in the amount of $25.00.

Review of CPT code 99358-52 date of service 08-15-03 revealed that neither the requestor nor the respondent submitted an EOB. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for an EOB. No reimbursement is recommended.

CPT code 99090 date of service 08-25-03 denied with denial code "G" (global). The carrier per Rule 134.202(a)(4) did not specify which code 99090 was global to. Reimbursement is recommended in the amount of $110.00 per the Medical Fee Guideline effective 08-01-03.

Review of CPT code 99358 date of service 08-26-03 revealed that neither the requestor nor the respondent submitted an EOB. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for an EOB. No reimbursement is recommended.

CPT code 99358 and 99358-52 dates of service 09-22-03, 10-09-03, 11-25-03 and 12-15-03 denied with denial code "G" (global). Code 99358 and 99358-52 are bundled codes, however, the carrier per Rule 134.202(a)(4) did not specify which code 99358 and 99358-52 were global to. Reimbursement is per the Medical Fee Guideline effective 08-01-03 in the amount of $336.00 ($84.00 X 4 DOS).

Review of CPT code 97039-59 date of service 09-15-03 revealed that neither the requestor nor the respondent submitted an EOB. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for an EOB. No reimbursement is recommended.

Review of CPT code 99213 date of service 09-15-03 revealed that neither the requestor nor the respondent submitted an EOB. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for an EOB. No reimbursement is recommended.

CPT code G0283 date of service 10-22-03 denied with denial code "G" (global). The carrier per Rule 134.202(a)(4) did not specify which code G0283 was global to. Reimbursement is recommended in the amount of $16.63 per the Medical Fee Guideline effective 08-01-03.

CPT code 99199 date of service 04-01-03 per the EOB indicates payment made in full check numbers 07470482 and 07238727, code 99361 date of service 04-11-03 paid in full check number 05860804, code 99361 date of service 04-18-03 paid in full check number 05860803, code 99361 date of service 04-25-03 paid in full check number 05860803, code 97545-WH, 97546-WH and 99199 dates of service 08-11-03 and 08-12-03 were paid in full check number 07425680. These codes and dates of service will not be reviewed by the Medical Review Division as a dispute does not exist.

This Findings and Decision is hereby issued this 1st day of December 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) and in accordance with Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 03-10-03 through 12-15-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 1st day of December 2004.

Hilda H. Baker, Manager
Medical Dispute Resolution
Medical Review Division

HHB/dlh

November 23, 2004

NOTICE OF INDEPENDENT REVIEW DECISION
Amended Letter B

RE: MDR Tracking #: M5-04-1548-01
IRO Certificate #: 5348

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 55 year-old male who sustained a work related injury on ___. The patient reported that while at work he injured his lower back when he attempted to lift a pipe weighing approximately 300 pounds. The patient underwent lumbar x-rays on 2/27/03 and was diagnoses with I.V.D. prolapse, protrusion, herniation rupture, radiculitis, sprain/strain lumbar spine, and muscle spasm C/T/L spine. On 3/11/03 the patient underwent an EMG study that showed a left S1 radicular change. A MRI of the lumbar spine dated 3/31/03 indicated mild disc bulging at L3-4 and L5-S1, neural foraminal complex narrowing at L4-5, bilateral L5-S1 neural foraminal complex narrowing, and L3-4 right slightly greater than the left neural foraminal complex narrowing. Treatment for this patient's condition has included spinal adjustments of the lumbar spine, myofascial release, moist heat thermotherapy, low volt Galvanic current, hydrotherapy, passive, active and progressive resistive range of motion exercises, and therapeutic exercises. The patient also participated in a pain management program.

Requested Services

Therapeutic procedure, conf by phys, unlisted service, WP-somato sens test, WP-needle electromyography, prolonged eval, mus test extremity, analysis of data stored in comp, conductive paste, needles only sterile, unlisted modality, hot/cold pack ther, electrical stimulation unattended, mp-office visit with manipulation, office visit, neuromuscular reeducation, ther exer, electrical stim unatt, and mechanical traction from 3/10/03 through 11/13/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 55 year-old male who sustained a work related injury to his lower back on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient have included I.V.D. prolapse, protrusion, herniation rupture, radiculitis, sprain/strain lumbar spine, and muscle spasm. The ___ chiropractor reviewer further noted that treatment for this patient's condition has included spinal adjustments, myofascial release, moist heat thermotherapy, low volt Galvanic current, hydrotherapy, passive, active, and progressive resistive range of motion exercises, therapeutic exercises, and pain management program. The ___ chiropractor reviewer indicated that the patient underwent extensive care beginning 2/20/03 with some improvement noted the beginning of 4/03. The ___ chiropractor reviewer explained that from the beginning of 4/03 through the middle of 5/03, there was no objective or subjective improvement. The ___ chiropractor reviewer indicated that after 3 months of conservative care for treatment of a disc bulge without herniation, the treatment is no longer medically necessary. The ___ chiropractor reviewer explained that once a patient has plateaued after 4-6 weeks of treatment, that patient should be referred out for other types of care, or discharged from treatment. The ___ chiropractor reviewer indicated that as long as the patient shows continued improvement, treatment should continue. However, the ___ chiropractor reviewer explained that this patient showed more benefit from the medication rather than from the multitudes of treatments provided. The ___ chiropractor reviewer further explained that the patient showed no improvement in his condition from early 4/03 through 12/03. Therefore, the ___ chiropractor consultant concluded that the therapeutic procedure, conf by phys, unlisted service, WP-somato sens test, WP-needle electromyography, prolonged eval, mus test extremity, analysis of data stored in comp, conductive paste, needles only sterile, unlisted modality, hot/cold pack ther, electrical stimulation unattended, mp-office visit with manipulation, office visit, neuromuscular reeducation, ther exer, electrical stim unatt and mechanical traction from 3/10/03 through 5/20/03 were medically necessary to treat this patient's condition. However, the ___ chiropractor consultant further concluded that the therapeutic procedure, conf by phys, unlisted service, WP-somato sens test, WP-needle electromyography, prolonged eval, mus test extremity, analysis of data stored in comp, conductive paste, needles only sterile, unlisted modality, hot/cold pack ther, electrical stimulation unattended, mp-office visit with manipulation, office visit, neuromuscular reeducation, ther exer, electrical stim unatt and mechanical traction from 5/21/03 through 12/15/03 were not medically necessary to treat this patient's condition.

Sincerely,